SPINE AND ORTHOPAEDIC INSTITUTE

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PATIENT INFORMATION SHEET

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____ **CITY:** _____ **ST:** _____ **ZIP:**_____

HOME PHONE: _____ **ALT. /CELL PHONE:** _____

S.S. #:_____ **DL#**_____ **EMAIL:** _____

BIRTHDATE: _____ **AGE:** _____ **MALE ( ) FEMALE ( ) MARITAL STATUS: M S D W**

CURRENT EMPLOYER: _____
ADDRESS: _____ **CITY:** _____ **ST:** _____ **ZIP:** _____
PHONE: _____ **OCCUPATION:** _____

******Where you injured on the job? YES / NO**

SPOUSES NAME: _____ **EMPLOYER NAME:** _____
EMPLOYER ADDRESS: _____
CITY: _____ **ST:** _____ **ZIP:** _____ **PHONE:** _____ **OCCUPATION:** _____

EMERGENCY CONTACT (OTHER THAN SPOUSE)
NAME: _____ **HOME PHONE #**_____
ADDRESS: _____ **CITY:** _____ **ST:**_____ **ZIP:** _____

PRIMARY CARE/ TREATING PHYSICIAN:
CLINIC NAME: _____ **PHYSICIAN NAME:** _____
ADDRESS: _____ **PHONE NUMBER:** _____ **FAX NUMBER:**_____

INSURANCE: Circle one: Private / Worker's Comp

INS.NAME:_____ **ID#**_____ **GP#**_____

ADDRESS _____ **CITY**_____ **ST**_____ **ZIP**_____

PHONE _____ **FAX**_____ **EMAIL:**_____

MEDICARE ASSIGNMENT FOR COVERED SERVICES: I CERTIFY THE INFORMATION GIVEN IN APPLYING FOR PAYMENT ID IS CORRECT AND REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

ASSIGNMENT OF BENEFITS: ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT TO SPINE & ORTHOPAEDIC INSTITUTE (SOI) FOR MEDICAL SERVICES. I REPRESENT THAT I HAVE INSURANCE COVERAGE AND DO HEREBY AUTHORIZE SOI TO RELEASE AND OBTAIN ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. IF MY INSURANCE FAILS TO PAY SOI FOR ANY REASON I AGREE TO PAY ALL UNPAID BALANCES.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY SPINE AND ORTHOPAEDIC INSTITUTE OF ANY CHANGES IN MY INFORMATION.

SIGNED: _____ **DATE:** _____

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